

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07380

Reg. Dist. No. 939

1. PLACE OF DEATH:

County Thiomas
 City or town Sabikun
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 64 years
 Hospital, institution, or street address where death occurred:
304 Charles St.
 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Thiomas
 City or town Sabikun
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 304 Charles St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Lena G. Bennett

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Charles E. Bennett
 6.(c) If alive, give age 79 years
 7. Birth date of deceased (mo., day, yr.) June 18, 1870
 8. AGE: Years 76 Months 1 Days 0 If less than one day
hrs. min.

9. Birthplace Sussex Co., Delaware
 (Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Madison St. Coars
 13. Birthplace Sussex Co., Delaware
 14. Maiden name Ellen J. Carson
 15. Birthplace Sussex Co., Delaware

16. Informant Charles E. Bennett
 Address Sabikun, Md.

17. Burial Date thereof 7/20/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium St. Marys
 Location Sabikun, Md.

19. Funeral director Edo Webb Johnson Co.
 Address Sabikun, Md.

19. 7/20/46 19. 46 Harriet E. Johnson
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1946, at 7:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18, 1946 to July 17, 1946 and that I last saw him alive on July 17, 1946

Immediate cause of death Carcinoma of face & throat DURATION 6 yrs.

Due to

Due to

Other condition Same as above

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

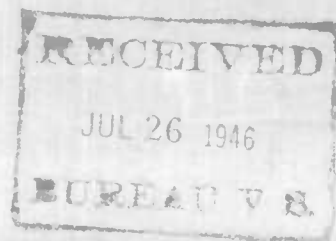
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John R. Mann

M. D. or other

Address 1946 Date signed 7/19/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DATE OF BIRTH: Letter
from Dr. Rademaker filmed
9-3-46 G106 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

CERTIFICATE OF DEATH

07387

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wilkes
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Two months
Hospital, institution, or street address where death occurred: na
How long in hospital or institution? na

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Wilkes
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. na
(If rural, give LOCATION) na
2. (a) If veteran, name war

3. (a) FULL NAME

Robert Prigg Beverly
4. Sex male 5. Color or race a.a. 6. (a) Single, married, widowed, or divorced na

3. (b) Social Security Number

Was Buried with

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30-46 at 2 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Aug 3 1946

Immediate cause of death

Burns of
intrac body

DURATION

sudden
death

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-30-46

Where did injury occur? Frederick Wilkes MD
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

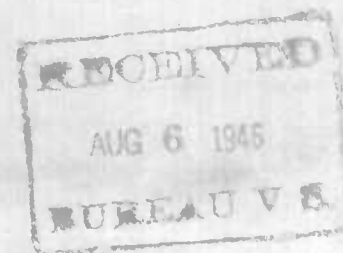
Means of injury House caught Injured at work? no

fire probably ignited in bed
for Rademaker MD

23. SIGNATURE Dr. H. H. Stewart M. D. or Other

Address Frederick MD Date signed 7/31/46

6. (b) Name of husband or wife na
6. (c) If alive, give age na years
7. Birth date of deceased (mo., day, yr.) Apr 7 1912 1907
8. AGE: Years 39 Months 3 Days 18 If less than one day na hrs. na min.
9. Birthplace Washington na
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business same as above
12. Name Early Beverly
13. Birthplace Washington na
14. Maiden name Honnie Huffman
15. Birthplace Washington na
16. Informant Eddie Muller
Address Frederick MD
17. Burial Date thereof Aug 3 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Meadowview na
Location Glades Spring
18. Funeral director James H. Stewart
Address Frederick MD
19. Date signed by registrar 7/31 19 46 Registrar Dr. H. H. Stewart



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93d)

CERTIFICATE OF DEATH

07388

Reg. Dist. No. 333

1. PLACE OF DEATH:

County McCombs

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County McCombs

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. Forman Ave. 4409 Smith St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Nellie Boles

3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

8.(b) Name of husband or wife Benjamin Franklin Boles

7. Birth date of deceased (mo., day, yr.) Jan. 18-1884

6.(c) If alive, give age Dead years

8. AGE: Years 62 Months 11 Days 1 If less than one day hrs. min.

9. Birthplace Milford Delaware
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER 12. Name John Dill

13. Birthplace McCombs Co. Md.

MOTHER 14. Maiden name Martha

15. Birthplace

16. Informant George W. Boles

Address 609 N. Main St. Salisbury Md.

17. Burial (Burial, cremation, or removal) Which? Burial Date thereof July 31, 1946
(month) (day) (year)

Cemetery or crematory Parson's Cem.

Location Salisbury Md.

18. Funeral director William H. G. Walter R. Williams

Address Salisbury Md.

19. 7/31/46 Barry Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29th 19 46, at 7 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 16, 1946 to July 29, 1946

and that I last saw him alive on July 23, 1946

Immediate cause of death Acute cardiac failure

Due to Chronic myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE George W. Boles M. D. or other

Address Salisbury Md. Date signed 7-31-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

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AUG 6 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Gray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1370

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: *Salisbury*
County *Wicomico*
City or town *Salisbury*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *47 years*
Hospital, institution, or street address where death occurred: *407 Baker street*
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State *Md.* County *Wicomico*
City or town *Salisbury*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *407 Baker st.*
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME *Woodland Francis Brunningham* 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widower*
6. (b) Name of husband or wife *Rosa E. Brunningham*
6. (c) If alive, give age *Dead* years
7. Birth date of deceased (mo., day, yr.) *July 23-1868*
8. AGE *77* Years Months *11* Days *18* If less than one day hrs. min.
9. Birthplace *Summit Co. Md.*
(Town, county, and state)

10. Usual occupation *Laborer*
11. Industry or business *William Brunningham*
12. Name *William Brunningham*
13. Birthplace *Summit Co. Md.*
14. Maiden name *Sallie Ann Cottman*
15. Birthplace *Summit Co. Md.*

16. Informant *Mrs. Mildred Penroy*
Address *407. Baker St. Salisbury Md.*
17. Burial *Funeral Home*
(Burial, cremation, or removal. Which?) Date thereof *July 15-1946*
(month) (day) (year)
Cemetery or crematory *Salisbury Md.*
Location *Holloman + Co. Walter R. Holloman*

18. Funeral director *Salisbury Md.*
Address

19. *7/15/46*
(Date read by registrar) Registrar *James A. Johnson*

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 11th* 19 *46* at *5:40 p.m.*
21. CERTIFY that death occurred on the date above stated; that I attended deceased from *about* 19 *45* to *July 11* 19 *46*
and that I last saw him alive on *July 19* 19 *46*
Immediate cause of death *Uremia*
Due to *Arteriosclerotic C-V-R*
Other conditions *Disease*
(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE *William O. Gray, M.D.*
Address *Salisbury Md.* Date signed *7/12/46*

RECEIVED

JUL 22 1946

BUREAU V S

PROSECUTOR GENERAL

200 CENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

07390

★ Reg. Dist. No. 389

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal) Which?

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. (Data rec'd by registrar)

19. (Data rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where)?

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED
JUL 12 1946
BUREAU V P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07391

336

CERTIFICATE OF DEATH

Reg. Diat. No. 11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County WicomicoCity or town Delmar
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 36 years

Hospital, institution, or street address where death occurred:

301 Chestnut St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Delmar
(If outside city or town limits, write RURAL and give nearest town)Street No. 301 Chestnut
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

James Franklin Cox

3. (b) Social Security Number

222-03-17704. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Arietta Cox8. (c) If alive, give age 35 years7. Birth date of deceased (mo., day, yr.) Sept - 11th, 19098. AGE: Years 36 Months Days If less than one day

hrs. min.

9. Birthplace Delmar, Ind.
(Town, county, and state)10. Usual occupation Truck11. Industry or business Truck12. Name See Cox13. Birthplace Salisbury, Ind.14. Maiden name May Ethel Brown15. Birthplace Wicomico County, Ind.16. Informant See CoxAddress Delmar, Del.17. Burial Date thereof 7-13-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory M. &Location Delmar, Del.18. Funeral director W. S. Mansel CoAddress Delmar, DelawareDate rec'd by registrar July 13, 46Registrar Harry E. Hudson Sr.Address Delmar, Del.Date signed July 12, 46

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11th 1946 at 11:40 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1946 to July 11, 1946and that I last saw him alive on July 10, 1946Immediate cause of death Heart failureby P.B. of long standingDue to embolism of lungsDue to arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Lynch

M. D. or other

Address Delmar, Del.Date signed July 12, 46

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JUL 15 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (101)

CERTIFICATE OF DEATH

07392

Reg. Dist. No. 939

1. PLACE OF DEATH: *Wilomile*
 County.....
 City or town.....*Salisbury Md*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....*one day*
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution?.....*one day*

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*Md* County.....*Wilomile*
 City or town.....*Salisbury Md*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....*200 1/2 Delaware*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....*no*

3. (a) FULL NAME
Dashie H. Harry

3. (b) Social Security Number
no

4. Sex.....*male* 5. Color or race.....*a.a.* 6.(a) Single, married, widowed, or divorced.....*married*
 6.(b) Name of husband or wife.....*Lillie Dashiell*
 7. Birth date of deceased (mo., day, yr).....*yes* 6.(c) If alive, give age.....*Don't know* years
 8. AGE: Years.....*08* Months..... Months Days..... Days If less than one day.....*about 1887* hrs. min.

9. Birthplace.....*Salisbury Md*
 (Town, county, and state)

10. Usual occupation.....*laborer*

11. Industry or business.....*same as above*

12. Name.....*James Dashiell*

13. Birthplace.....*Myrdella and*

14. Maiden name.....*Phoebe Pinkett*

15. Birthplace.....*Rachawalkin Md*

16. Informant.....*Lillie Dashiell*

Address.....*Salisbury Md*

17. *Official* (Date thereof.....*July 11, 1946*)

Cemetery or crematory.....*Houston*

Location.....*Salisbury Md*

18. Funeral director.....*James Stewart*

Address.....*Salisbury Md*

19. *7/11/46* (Date signed by Registrar)

20. *Patrick J. Johnson* (Signature of Registrar)

Address.....*Salisbury Md*

Date signed.....*7/18/46*

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*7-8* 19*46*, at *2:45* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *7-8* 19*46* to *7-8* 19*46* and that I last saw him alive on *7-8* 19*46*

Immediate cause of death.....*Burns of chest & arms* DURATION.....*1 day*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....*none*

Date of op.....

Autopsy results.....*none*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....*Accident* Date of.....*7-7-46*

Where did injury occur?.....*Salisbury Md* (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....*Home*

Means of injury.....*Bed caught fire* - Injured at work?.....*no*

Signature.....*J. Padonahor MD*

Address.....*Salisbury Md*

Date signed.....*7/18/46*

23. SIGNATURE.....*Patrick J. Johnson* M. D. or other

Address.....*Salisbury Md*

Date signed.....*7/18/46*

RECEIVED
JUL 16 1946
BUREAU V B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-2

07393

CERTIFICATE OF DEATH

Reg. Dist. No. 739

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex.....
 5. Color or race.....
 6. (a) Single, married, widowed, or divorced.....
 6. (b) Name of husband or wife.....
 8. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min.
 9. Birthplace.....
 (Town, county, and state)

10. Usual occupation.....
 11. Industry or business.....
 12. Name.....
 13. Birthplace.....
 14. Maiden name.....
 15. Birthplace.....

16. Informant.....
 Address.....
 17. (Burial, cremation, or removal. Which?)..... Date thereof.....
 (month) (day) (year)
 Cemetery or crematory.....
 Location.....
 18. Funeral director.....
 Address.....
 19. (Date rec'd by registrar).....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....
 and that I last saw him/her alive on.....
 Immediate cause of death.....
 DURATION.....
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?
 23. SIGNATURE.....
 M. D. or other
 Address..... Date signed.....

RECEIVED
JUL 12 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

Reg. Dist. No. 939

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 days - 7 hrs
 Hospital, institution, or street address where death occurred:
Pennsila General Hospital
 How long in hospital or institution? 5 days - 7 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Crumor & Gts. 7th Div. 4
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Dennis, Mary Hattie

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife William Lester Dennis
 7. Birth date of deceased (mo., day, yr.) Sept. 16 - 1902 6. (c) If alive, give age Dead years
 8. AGE: Years 43 Months 10 Days 2 If less than one day hrs min.

9. Birthplace near Fruitland Md.
 (Give, county, and state)

10. Usual occupation Clark at

11. Industry or business U.S. Post Office Salisbury Md.

12. Name H. Durand 13. Birthplace near Fruitland Md.

14. Maiden name Mary E. Fitch 15. Birthplace near Fruitland Md.

16. Informant Mrs. Mary E. Fitch
 Address R. # 11, Salisbury Md.

17. Burial (Burial, cremation, or removal, Which?) Buried Date thereof July 20 - 46
 (month) (day) (year)

Cemetery or crematorium Pennsila Gen.
 Location Salisbury Md.

18. Funeral director Hillman & G. Walter R. Hillman
 Address Salisbury Md.

19. 7/20, 1946 Registrar Harriet E. Johnson
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 46 at 4:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 19 46 to July 18 19 46
 and that I last saw him alive on July 17 19 46

Immediate cause of death Coronary Thrombosis DURATION 4 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE H. Durand M. D. or other

Address Salisbury Md. Date signed July 18

RECEIVED
JUL 26 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 173

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7-18-46 - 7-20-46
Hospital, institution, or street address where death occurred:
General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County Queen
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Dickerson, Randall

3. (b) Social Security Number

4. Sex Male 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Gene Dickerson
6. (c) If alive, give age 21+ years
7. Birth date of deceased (mo., day, yr.) Jan 6 1914
8. AGE: Years 32 Months 32 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Delaware
(Town, county and state)
10. Usual occupation Mr. Louis Dickerson Co.
11. Industry or business Day Care
12. Name Edward H. Dickerson
13. Birthplace Delaware
14. Maiden name Mary Phillips
15. Birthplace Delaware

16. Informant E. H. Dickerson
Address Laurel Del.
17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof July 20, 46
(month) (day) (year)
Cemetery or crematory Old Laurel Cemetery
Location Laurel Del.

18. Funeral director Harvey Williamson
Address Fredericksburg Md.

19. (Date rec'd by registrar) 7/23/46 Registrar Harvey Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1946 at 7:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____
and that I last saw him _____ alive on a medical certificate _____
Immediate cause of death Shock
DURATION 2 days
Due to Congenital heart disease
Due to prolonged fever
8 fibrils left
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings of operations as above
Date of op. 7-20-46
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 7-18-46
Where did injury occur? near Salisbury Del.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home?
Means of injury Plane disaster Injured at work? yes
Signature Dr. Raymond M. D.
Address Salisbury Md. Date signed 7/20/46

MARGIN RESERVED FOR BINDING

VS A15

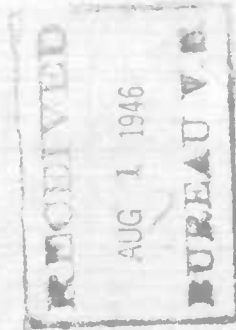
9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07395

Plane used for dusting crops
struck wire in landing, producing
above injuries.

J. A. Rodencher M.D.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07396

Reg. Dist. No. 933

1. PLACE OF DEATH: Wilcomie
County Salisbury
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 years
Hospital, institution, or street address where death occurred:
302 Mount Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Wilcomie
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 302 Mount St.
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME Rona Endora Disharoon

3. (b) Social Security Number

4. Sex female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife George H. Disharoon
6. (c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) Aug. 30 - 1891
8. AGE: Years 54 Months 10 Days 8 If less than one day
hrs. min.

9. Birthplace Wilcomie Co. Md.
(Town, county, and state)

10. Usual occupation Home wife

11. Industry or business at home

FATHER 12. Name Alexander H. Malone

13. Birthplace Wilcomie Co. Md.

MOTHER 14. Maiden name Sallie M. Malone

15. Birthplace Maryland

16. Informant Mr. George H. Disharoon

Address 302 Mount St. Salisbury Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof July 10 - 1946
(month) (day) (year)

Cemetery or crematorium Parson's Cem.

Location Salisbury Md.

18. Funeral Director Walter H. G. Walter R. Hall

Address Salisbury Maryland.

19. 7/9/46 (Date rec'd by registrar)

Registrar Therese L. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8th 1946, at 130 P M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw deceased at home 1946

Immediate cause of death Carcinoma of uterus

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations same

Antemortem results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Therese L. Johnson M. D. or other

Address Salisbury Md. Date signed 7/9/46

MARGIN RESERVED FOR BINDING

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9-45-1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 12 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on Film No. 106 - 7/24/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

07397

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Salisbury
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred: P.B. Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Neomic
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 303 Ohio
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Anna Mae Downer

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband Lea Downer
 6. (c) If alive, give age Dead years
 7. Birth date of deceased (mo., day, yr.) Dec. 21 - 1882
 8. AGE: Years 62 Months 4 Days 11 If less than one day _____ hrs. _____ min.
 9. Birthplace Dagobert Del.
 (Town, county, and state)
 10. Usual occupation Home wife
 11. Industry or business unknown

12. Name Delaware
 13. Birthplace Carrie Carr
 14. Maiden name Surrey Co.
 15. Birthplace Del.
 16. Informant Mrs. Betty Banks
 Address 303 Ohio Ave. Salisbury Md
 17. Burial (Burial, cremation, or removal. Which?) Buried Date thereof July 6, 1946
 (month) (day) (year)
 Cemetery or crematory Neomic Mem. Park
 Location Salisbury Md.
 18. Funeral director Hollings G. Walter R. Hollings
 Address Salisbury Maryland
 19. 7/6/46 19 46 Registrar W. E. Johnson
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2nd 1946 at 10:45 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 19 46 to July 2 19 46
 and that I last saw her alive on July 2 19 46
 Immediate cause of death Coronary thrombosis
 Due to _____
 Due to _____
 Other conditions Chronic Myocarditis
Chronic calcareous cholelithiasis - Biliary fistula
 (Include pregnancy within 3 months of death)
 Major findings of operations Chronic Calculey
Cholelithiasis Date of op. 5/20/46
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE J. Rademacher M. D. or other _____
 Address Salisbury Md Date signed 7/3/46

IVED
JUL 12 1946
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 556

CERTIFICATE OF DEATH

07398

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Willards
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Dallie A. Downs

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife John A. Downs7. Birth date of deceased (mo., day, yr.) May 15, 18786. (c) If alive, give age ✓ years8. AGE: Years 68 Months 2 Days 16 If less than one day
hrs. min.9. Birthplace Willards, Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Housework12. Name Benjamin Hall13. Birthplace Md.14. Maiden name Percilla Baker15. Birthplace Md.16. Informant Oliver DownsAddress Willards Md.17. Burial Date thereof Aug 3, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bible ChurchLocation near Willards, Md.18. Funeral director M. Pasha WatsonAddress Selkville, Del.19. 8/5- 19 46 Registrar Frank J. Jones

(Date reg'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Willards
(If outside city or town limits, write RURAL and give nearest town)Street No. 1778

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 19 46 at 10: P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1, 1946 to 7-31-46 days of deathand that I last saw him ✓ alive on 7-31-46 19 46Immediate cause of death Carcinoma (Sarcoma) lefttibia

DURATION

Due to

Due to

Other conditions Hypertension

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Jones M. D. or otherAddress Willards Maryland Date signed 8-4-46

RECEIVED

CERTIFICATE OF DEATH

RECEIVED

AUG 8 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83-2

07399

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Vienna Co
 County Salisbury
 City or town 4 months
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital institution, or street address where death occurred:
105 Cherry street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Vienna Co
 City or town Freeland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Cecie Blanche Dykes

3. (b) Social Security Number

4. Sex female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Laselle Dykes

6. (c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Jan. 31 - 1880

8. AGE: Years 66 Months 5 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Vienna Co. Md.
 (Town, county, and state)

10. Usual occupation Home life

11. Industry or business _____

12. Name Spencer Catlin

13. Birthplace Vienna Co. Md.

14. Maiden name Katherine McCreath

15. Birthplace Vienna Co. Md.

16. Informant Mrs. Lillian M. Weaver

Address 616 E. 22nd St. Wilmington Del.

17. Buried Date thereof July 13, 1944
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Greenwood

Location near Freeland Md.

18. Funeral director Hollman & Co. Walter P. Hollman

Address Salisbury Md.

19. 7/13/44 19. Dr. Harriet E. Johnson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1946 19. 46 2. 55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10, 1946 to July 10, 1946
 and that I last saw him alive on July 10, 2:00 PM

Immediate cause of death Broncho pneumonia DURATION 4 days

Due to Cerebral Hemorrhage 5 years

Due to Hypertension 2

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert Isaac M. D. or other _____

Address Salisbury Md. Date signed 7-12-46

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JUL 22 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on

2411 N. Charles St., Baltimore 92-2

CERTIFICATE OF DEATH

Reg. Dist. No. 07400 330

FILM No. 1-06 JUL 25 1946

1. PLACE OF DEATH:

County Thomson
City or town Mardela, Md. RA
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ida A. Lambill

3. (b) Social Security Number

4. Sex F 5. Color of race White 6. (a) Single, married, widowed, or divorced Married

B. (b) Name of husband or wife Herman Lambill

7. Birth date of deceased (mo., day, yr.) Dec 1 1884 B. (c) If alive, give age 58 years

8. AGE: Years 61 Months 62 Days 7 If less than one day 9 hrs. 9 min.

9. Birthplace Thomson Co., Md.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business

12. Name William S. Phillip
13. Birthplace Md.

14. Maiden name Charlotte A. Horseman
15. Birthplace Md.

16. Informant Herman Lambill
Address Mardela, Md. RA.

17. (Burial, cremation, or other? Which?) Burial Date thereof 7-12-1946
(month) (day) (year)
Cemetery or crematory Athel Baptist Cemetery

Location Englewood Bros
18. Funeral director Sharpstown, Md.
Address

19. 7/12/46 19. W. H. Kuhlman
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Thomson
City or town Mardela Md. RA.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1946 at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1946 to July 9 1946 and that I last saw him alive on July 9 1946

Immediate cause of death Coronary Occlusion

DURATION

1 hr

Due to

Due to

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. S. Kuhlman

M. D. or other

Address Sharpstown Md Date signed 7/10/46

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JUL 15 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07401

Reg. Diat. No.

337

1. PLACE OF DEATH:

County Wisconsin
 City or town Wausau
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Wisc County Wisconsin
 City or town Wausau
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

George W. Goulke

3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6.(a) Single, married, widowed, or divorced widower
 6.(b) Name of husband or wife Myrtle E. Goulke
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Feb. 7, 1872
 8. AGE: Years 74 Months 6 Days 12 If less than one day
 hrs. min.

9. Birthplace Wausau, Wisc.
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business
 12. Name John R. Goulke
 13. Birthplace Wausau, Wisc.
 14. Maiden name East Kanner
 15. Birthplace

16. Informant Clarence Goulke
 Address Wausau
 17. Burial Date thereof 7/24/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Wausau
 Location Head of Creek Church
 18. Funeral director E. J. Goulke
 Address Bismarck
 19. 7/23 19 46 R. W. Wolford
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 46 at 10:40 p.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 19 46 to July 21 19 46
 and that I last saw him alive on July 21 19 46

Immediate cause of death Pneumonia DURATION 22 days

Due to

Due to

Other conditions Senility

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Goulke MD M. D. or otherAddress Wausau Date signed 7-23-46

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AUG 6 1946
BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

07402

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 4 days 20 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worce.City or town Stockton
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war _____ ☒

3. (a) FULL NAME

Edward F. Hancock

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Bettie Hancock6. (c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) April 5-18688. AGE: Years 78 Months 3 Days 25 If less than one day _____ hrs. _____ min.9. Birthplace Pocomoke Wicomico Md.
(Town, county, and state)10. Usual occupation Farming

11. Industry or business _____

12. Name John Hancock13. Birthplace Md.14. Maiden name Elizabeth Redden15. Birthplace Md.16. Informant Edwin HancockAddress Stockton Md.17. Burial Date thereof Aug 2-1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Gordwill M.E. CemeteryLocation Rural Pocomoke Md.18. Funeral director Sherry S. SlatonAddress Pocomoke Md.19. 8/5/46 1946 Harriet E. Johnson Registrar

(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1946, at 3:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 26, 1946 to July 30, 1946and that I last saw him/her alive on July 30, 1946Immediate cause of death _____ DURATION 5 daysDue to Intestinal obstructionDue to Carcinoma of colonDue to Splenic flexure of colonDue to Splenic flexure of colon

Other conditions _____

Major findings of operations Carcinoma of colonDate of op. 7/26/46Autopsy results not

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

19. SIGNATURE L. Raden M. D. or other _____Address Salisbury Md. Date signed 7/31/46

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AUG 8 1946

BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12

CERTIFICATE OF DEATH

07403

Reg. Dist. No. 933

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days - 17 1/2 hrs
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? 2 days - 17 1/2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
MD. Somerset
 State MD. County Somerset
 City or town Deal Island
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION) ✓
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Harris, Mrs. Bernice

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Monnie Harris

7. Birth date of deceased (mo., day, yr.) Oct. 17-1894
 6. (c) If alive, give age 55 years

8. AGE: Years 51 Months 9 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Deal Island Md.
 (Town, county, and state)

10. Usual occupation Home wife

11. Industry or business at home

FATHER 12. Name Gamer Shoue

13. Birthplace Deal Island Md.

MOTHER 14. Maiden name Ada Webster

15. Birthplace Deal Island Md.

16. Informant M. Monnie Harris

Address Deal Island Md.

17. (Burial, cremation, or removal) Which? Burial Date thereof July 21-46
 (month) (day) (year)

Cemetery or crematory St. John's M.E. Church

Location Deal Island Md.

18. Funeral Director L. B. Webster

Address Deal Island Md.

19. 7/21/46 Registrar Harris, E. Thomas
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 46, at 7:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15/46 to July 18/46
 and that I last saw him alive on July 17/46

Immediate cause of death Respiratory failure DURATION 3 days

Due to Tetanus

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert R. Starr M. D. Starr

Address Salisbury Md. Date signed 7-18-46

500 N. Salisbury St.

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AUG 1 1946

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

★ Reg. Dist. No. 399

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 days - 12 hrs
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 30 days - 12 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION) ✓
2.(a) If veteran, name war _____

3. (a) FULL NAME

Harrison, Mrs. Ada H.

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced
6.(b) Name of husband or wife Orlando Harrison
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) July 9, 1865
8. AGE: Years 80 Months 11 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Capt. Henry H. Long
13. Birthplace Delaware
14. Maiden name Mary Hickman
15. Birthplace Delaware

16. Informant Mrs. Ada Harrison
Address Berlin Md

17. Burial Date thereof 7/9/46
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Evergreen
Location Berlin Md

18. Funeral director James A. Burhop
Address Berlin Md

19. 7/9/46 1946 Harrist E. Johnson
(Date rec'd by registrar) (year) (month) (day) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1946 at 8:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-6-46 1946 to 7-7 1946 and that I last saw him alive on 7-7 1946

Immediate cause of death Pneumonia

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Lud R. Grand M. D. or other _____

Address Salisbury, Md Date signed 7-7-46

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 12 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115-6)

CERTIFICATE OF DEATH

Reg. Diat. No. 07405 233

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days - 1 1/2 hours
 Hospital, institution, or street address where death occurred:
Brimmala General Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Somerset
 City or town Weston
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ✓
 (If rural, give LOCATION)
 2. (a) If veteran, name war ✓

3. (a) FULL NAME

Constance Jean Hill

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced child

6. (b) Name of husband or wife —

7. Birth date of deceased (mo., day, yr.) Nov 5, 1937 6. (c) If alive, give age — years

8. AGE: Years 8 Months 8 Days 16 If less than one day — hrs. — min.

9. Birthplace Philadelphia Phila Pa.
 (Town, county, and state)

10. Usual occupation School child11. Industry or business —12. Name Benjamin Hill13. Birthplace Richmond Va.14. Maiden name Anna Mae Osters15. Birthplace Philadelphia Pa16. Informant Annamae OstersAddress Weston Md17. Burial Date thereof July 29, 1946

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cottage groveLocation Weston Md18. Funeral director Charles H WardAddress Marion Md.19. 7/23, 1946 Registrar Harris E. Johnson

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 19 46, at 4:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 19 46 to July 20 19 46and that I last saw him alive on July 20 19 46Immediate cause of death Strep throat & sore throat DURATION 8 daysDue to —Due to —Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations — Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Wm. H. D. M. D. or other —Address — Date signed July 22

RECEIVED

AUG 1 1946

BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

7406
X 336

1. PLACE OF DEATH:

County DelawareCity or town Delmar
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 hrsHospital, institution, or street address where death occurred:
East Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del. County DelawareCity or town Delmar
(If outside city or town limits, write RURAL and give nearest town)Street No. 100
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary E. Stithers

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow6.(b) Name of husband or wife Levy Stithers6.(c) If alive, give age 1 years7. Birth date of deceased (mo., day, yr.) Dec 16 18658. AGE: Years 80 Months 7 Days 9 If less than one day 1 hrs. 1 min.9. Birthplace Delaware
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name Michael Keen13. Birthplace Delaware14. Maiden name Jacob J. Orsini15. Birthplace Delaware16. Informant Mrs. Harry J. AndersonAddress Delmar, Del.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof July 28 46
(month) (day) (year)Cemetery or crematory Delaware CemeteryLocation Delmar, Del. R.F.18. Funeral director J. H. H. H. H. H.Address Delmar, Del.

19. July 27. 1946 Harry E. Anderson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 46 at 9:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 46 to July 25 46and that I last saw him alive on July 25 46Immediate cause of death Coronary Thrombosis

DURATION

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. V. Bohler, M.D. M. D. or otherAddress Delmar, Del. Date signed July 29 46

hp Windsor
Lancel
WEL

JUL 29 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WorcesterCity or town Seabrook
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 days - 16 hrs

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 13 days - 16 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WorcesterCity or town Ocean City
(If outside city or town limits, write RURAL and give nearest town)Street No. St Louis Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME

Jones, Mrs Carrie

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed8. (b) Name of husband or wife George Jones7. Birth date of deceased (mo., day, yr.) March 26, 18826. (c) If alive, give age — years8. AGE: Years 64 Months 3 Days 16 If less than one day — hrs. — min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name James Smiles13. Birthplace md14. Maiden name Hannett Pennevell15. Birthplace md18. Informant Mrs. Zadoch JonesAddress Ocean City md17. Burial Date thereof 7/14/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EvergreenLocation Berlin md18. Funeral director James A. BarberAddress Bealiv, md19. 7/14/46 19. 46 Harriet Edithson
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 19 46 at 7:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 19 46 to July 12 19 46and that I last saw him alive on July 12 19 46Immediate cause of death Probably cerebral vascularaccidentDue to uterine polyp &operation

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Uterine polypDate of op. July 6 46Autopsy results No autopsy - no cause of death

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following: No

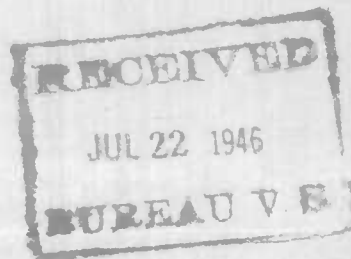
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Barber M. D. or otherAddress Salisbury, Md Date signed 7/13/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Pennsylvan General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Jones Mrs Margie4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Cleveland Jones7. Birth date of deceased (mo., day, yr.) July 27, 18888. AGE: Years 57 Months 11 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace Berlin md
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name James A. Bradford13. Birthplace md14. Maiden name Margaret H. Townsend15. Birthplace md16. Informant Mr. Cleve JonesAddress Berlin md17. Buried Date thereof 7/17/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EvergreenLocation Berlin md18. Funeral director Anna A. BarbeyAddress Berlin md19. 7/17/46 Harriet A. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 15- 1946 at 7:45 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 June 1946 to July 15 1946 and that I last saw him alive on July 8 1946Immediate cause of death myocardial infarction with pulmonary edemaDue to arteriosclerosisDue to cholesterolOther conditions senile dementia

(Include pregnancy within 3 months of death)

Major findings of operations chronic cholecystitis & cholelithiasis Date of op. 29 July 46

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE William B. Long md M. D. or other _____Address 504 N. Division St Date signed 7/16/46

RECEIVED
JUL 22 1946
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07409998
Reg. Dist. No.

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Penninsula General Hospital
Hospital, institution, or street address where death occurred:How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Jones Martha

3. (b) Social Security Number

4. Sex Female 5. Color or race Col 6. (a) Single, married, widowed, or divorced MARRIED6. (b) Name of husband or wife Eliwood Jones7. Birth date of deceased (mo., day, yr.) Jan. 13, 1881 6. (c) If alive, give age 72 years8. AGE: Years 65 Months 6 Days 5 If less than one day _____ hrs. _____ min.9. Birthplace Nanticoke, Wicomico, Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Jesse Barclay13. Birthplace Nanticoke, Md.14. Maiden name Sarah Barclay15. Birthplace Nanticoke, Md.16. Informant Eliwood JonesAddress Nanticoke, Md.17. Burial Date thereof 7/21/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Nanticoke CemeteryLocation near Justice Store18. Funeral director MississippAddress Bivalve, Md.19. 7/21/46 19. 46 Barrett L. Johnson
(Date rec'd by registrar) (Year) (Month) (Day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 46 at 1:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3, 19 46, to July 18, 19 46, and that I last saw him alive on July 18, 19 46.

Immediate cause of death _____ DURATION _____

Bronchial - pneumonia _____Due to Septic _____Due to Sanguine left foot & leg _____Due to Diabetes mellitus _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations Autopsy: none
sanguine left foot & leg Date of op. July 10, 1946

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William B. Long M.D. M.D. or other _____Address 504 N. Division St. Date signed July 18
Salisbury, Md.

RECEIVED

AUG 1 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(32)

07410

CERTIFICATE OF DEATH

Reg. Dist. No. 329

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days 13 hrs
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Sand
 City or town Danvers Quarters
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Jones, Willie

3. (b) Social Security Number

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Julia Jones

7. Birth date of deceased (mo., day, yr.) Not Obtainable 8. (c) If alive, give age _____ years

8. AGE: Years 54 Months _____ Days _____ If less than one day _____ min.

9. Birthplace Danvers Quarters
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Henry Jones

13. Birthplace Danvers Quarters

14. Maiden name Roxanna Jones

15. Birthplace Danvers Quarters

16. Informant Bertie Jones

Address Danvers Quarters MD

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof July 7th, 1946
 Cemetery or crematory Colonel James Quarters M.C.

Location Danvers Quarters MD

18. Funeral director Deal Island MD

Address _____

19. (Date rec'd by registrar) 7/5/46 Registrar Harriet E. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 19 46 at 1:00 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 29 19 46 to July 4 19 46

and that I last saw him alive on July 4 19 46

Immediate cause of death MYOCARDIAL INSUFFICIENCY, Acute

ARTERIOSCLEROTIC HEART DISEASE

with MYOCARDIAL HYPERTROPHY

& GENERALIZED ANEMIA

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations NONE

Date of op. _____

Autopsy results NONE

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James Hanson, M.D. M.D. or other _____

Address Salisbury, MD Date signed 7/4/46

RECEIVED
JUL 12 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

CERTIFICATE OF DEATH

07411

Reg. Dist. No. 333

1. PLACE OF DEATH:

County McCombsCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

312 E. William St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County McCombsCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 312 E. William St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Roger Edward Justice

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Margaret Alice Justice

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan 6th 18888. AGE: Years 58 Months 5 Days 25 If less than one day _____ hrs. _____ min.9. Birthplace New Church, Va.
(Town, county, and state)10. Usual occupation Auto Salesman11. Industry or business at McCombs Mtn. Co. Salisbury Md.12. Name George Hampton Justice13. Birthplace New Church Va.14. Maiden name Susan Kelley15. Birthplace New Church Va.16. Informant Mrs. Margaret Alice JusticeAddress 312 E. William St. Salisbury Md.17. Burial (Burial, cremation, or removal. Which?) Funeral Home Date thereof July 6-7-46
(month) (day) (year)Cemetery or crematory Salisbury Md.Location Salisbury Md.18. Funeral director William P. C. Miller R. HillmanAddress Salisbury Md.19. 7/6/46 (Date read by registrar) 1946 Registrar W. C. Smithland

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1946 at 11 P.M.21. CERTIFY that death occurred on the date above stated; that I attended deceased from 7-1-46 to 7-1-46and that I last saw him alive on 7-1-46Immediate cause of death Cerebral Hemorrhage DURATION 2 hrs.Due to Malignant Hypertension

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Injured at work? _____

23. SIGNATURE Lee L. Laury M.D. M. D. or other _____Address Salisbury Md. Date signed 7-5-46

RECEIVED
JUL 12 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07412

CERTIFICATE OF DEATH

Reg. Dist. No. 299

1. PLACE OF DEATH:

County Pennsylvania
City or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Pen. Pen. Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Florida County Dade

City or town Miami
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2464 S.W. 19th Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Bertram Robert Levy

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6-1924

8. AGE: Years 22 Months 0 Days 14 If less than one day hrs. min.

9. Birthplace New York City N. Y.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name David Levy

13. Birthplace New York N. Y.

14. Maiden name Beatrice Waling

15. Birthplace New York N. Y.

16. Informant Mrs. Beatrice Levy

Address 2464 S.W. 19th Avenue Miami Fla.

17. Burial Date thereof July 25-46

(Burial, cremation, or removal) Which? mt mbr Pen

Cemetery or crematory Miami, Florida

Location Holladay & Co. Walter R. Holladay

18. Funeral director Salisbury Maryland

Address 7/3/46

19. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1946 at 1:56 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1946 to July 22 1946

and that I last saw him alive on July 21 1946

Immediate cause of death Respiratory failure

Due to Encephalitis DURATION 1 day

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE Robert R. Star

M. D. or other

Address Salisbury Date signed 7-22-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-46

VS A15 9-45-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 1 1946
BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(940)

07413

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WilcomicoCity or town Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County WilcomicoCity or town Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Twilley Loney

3.(b) Social Security Number

4. Sex

Male

5. Color or race

a.c.

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

none

7. Birth date of deceased (mo., day, yr.)

about 1892

8.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

34

hrs.

min.

9. Birthplace

Packawalkin md
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

same as above

12. Name

unknown

13. Birthplace

unknown

14. Maiden name

one Hardy

15. Birthplace

Packawalkin

16. Informant

Mrs Mary Lunnell

Address

Salisbury md

17. Burial, cremation, or removal. Which?

Burial

Date thereof

July 16-1946
(month) (day) (year)

Cemetery or crematory

Packawalkin

Location

Packawalkin md

18. Funeral director

James Stewart

Address

Salisbury md

19. (Date rec'd by registrar)

7/16/46

19. 46

Barrett

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

7-1319. 46 at 8³⁰ P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ to _____

and that I last saw him _____

Immediate cause of death

Coronary occlusion

DURATION

rapid

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op. _____

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE Dr. PackawalkinWm. L. LunnellAddress Salisbury mdDate signed 7/13/46

RECEIVED
JUL 22 1946
BUREAU V.K.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: Salisbury
 County Wicomico
 City or town Salisbury, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 7/16/46
 Hospital, institution, or street address where death occurred:
E. S. Tb. Sanatorium, Salisbury, Md.
 How long in hospital or institution? Since 7/16/46

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Ocean City, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. No
 (If rural, give LOCATION)
 2.(a) If veteran, name war No

3. (a) FULL NAME
Ludlam, Anna Louise

3. (b) Social Security Number
None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Maurice Ludlam
 6.(c) If alive, give age 41 years
 7. Birth date of deceased (mo., day, yr.) July 12, 1912
 8. AGE: Years 34 Months 0 Days 10 If less than one day
hrs. min.

9. Birthplace Bishopville, Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Bergman
 13. Birthplace California

MOTHER 14. Maiden name Lilly Bunting
 15. Birthplace Maryland

16. Informant self
 Address

17. Burial Date thereof 7/24/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory EVERGREEN
BERLIN, MD.
 Location

18. Funeral director Anna B. Bunting
 Address Berlin Md.

19. 7/24/46 19. 46
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 19 46 at 7:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 16 19 46 July 22 19 46
 and that I last saw him alive on July 22, 1946 19 46

Immediate cause of death Pulmonary Tuberculosis DURATION 2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Ellen

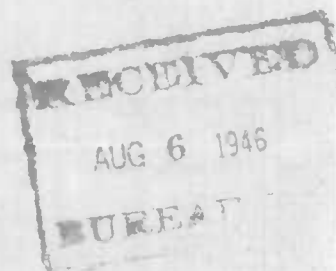
Shaw Hill, Md. M. D. or other 7/22/46

Address Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1190

CERTIFICATE OF DEATH

07415

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Kennelwood General HospitalHow long in hospital or institution? 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)

State Virginia County AccomackCity or town Wappsville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Marshall Michel

3. (b) Social Security Number

4. Sex

male

5. Color or race

W

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Aug. 15, 1945

8. AGE:

Years

Months

Days

If less than one day

10 36

hrs. min.

9. Birthplace

Accomack Co.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal) Which?

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19 46

7/13/46

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 16 19 46 at 10:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Medical Examination Certificate
and that I last saw h. alive on July 16 19 46

Immediate cause of death

Acute Retrolental Infection
Small
lungs

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Oliver Tucker MD
Physician Medical Examiner M. D. or other
Address Salisbury, Md. Date signed 7/14/46

RECEIVED
JUL 22 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 0711 933

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Unionville Memorial Hospital

How long in hospital or institution?

3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Rural Pocomoke Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Mr. Bride Charlie

3. (b) Social Security Number _____

5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mattie McBride6. (c) If alive, give age 42 years7. Birth date of deceased (mo., day, yr.) April 15-19038. AGE: Years 43 Months 2 Days 23 If less than one day _____ hrs. _____ min.9. Birthplace Wynnumburg, Berk, Georgia
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business _____

12. Name Zeinnet McBride13. Birthplace Georgia14. Maiden name Unknown

15. Birthplace _____

16. Informant Mattie McBrideAddress Rural Pocomoke Md.17. Burial Date thereat July 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Unionville CemeteryLocation Rural Pocomoke Md.18. Funeral director Henry H. WatsonAddress Pocomoke Md.19. 7/14/46 Harry L. Johnson
(Date recorded by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1946, at 3:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/5 1946 to 7/8 1946and that I last saw him alive on July 8 1946

Immediate cause of death _____ DURATION _____

MYOCARDIAL FAILURE, ACUTEDue to MALIGNANT HYPERTENSION ?

Due to _____

Other conditions Uremia

(Include pregnancy within 3 months of death)

Major findings of operations noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

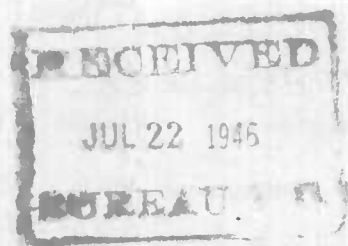
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. Fivers Hanson, M.D.
M. D. or other _____Address Salisbury Md. Date signed 7/8/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

07417
Reg. Dist. No. 239

1. PLACE OF DEATH:--

County Wicomico
City or town Salisbury - Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset
City or town Princess Anne, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

George B. McIntyre.

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

Norah McIntyre

7. Birth date of

deceased (mo., day, yr.)

April 3, 1861

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

85226

hrs.

min.

9. Birthplace

Mt Vernon
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal (which?))

Date thereof

July 30, 1946

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 46

19. 46

19. 46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1946 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 22 1946 to July 25 1946and that I last saw him alive on July 25 1946

Immediate cause of death

Myocarditis
Arteriosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank L. Quance M.D.Address Salisbury, Md. Date signed 7-28-46

RECEIVED

AUG 6 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(83-2)

07418

CERTIFICATE OF DEATH

Reg. Dist. No. 939

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County WicomicoCity or town Thoskin Rural (Clare)
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Carrie Robertson Mezick

3. (b) Social Security Number

4. Sex F 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Luther F. Mezick

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) August 21, 18708. AGE: Years 75 Months 10 Days 29 If less than one day _____ hrs. _____ min.9. Birthplace Thoskin, Wicomico Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name J. W. F. Robertson13. Birthplace Thoskin Md.14. Maiden name Ether Robertson15. Birthplace Thoskin Md.16. Informant Mrs. Ruby MezickAddress Salisbury Md. R.F.D. #217. Buried Date thereof 7/22/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Johns CemeteryLocation Fruitland Md.18. Funeral director David K. MessickAddress Glenora Md.19. 7/22/46 19. 46 Harriet E. Johnson
(Date rec'd by registrar) (Year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/20/46 19. 46 at 1 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 1st 19. 46 to July 13th 19. 46and that I last saw her alive on July 1st 19. 46Immediate cause of death Cerebral Hemorrhage

DURATION

Due to _____

Due to _____

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William Everich

M. D. or other

Address Helen Md. Date signed July 20th

RECEIVED

AUG 1 1946

BUREAU V.R.

Reg. Diat. No. 327

MARGIN-PRESERVED FOR BINDING

VS A15

9.45-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

<p>1. PLACE OF DEATH:</p> <p>County.....<u>Heron</u></p> <p>City or town.....<u>Heron</u> <small>(If outside city or town limits, write RURAL and give nearest town)</small></p> <p>How long in above place of death?.....<u>4 years</u></p> <p>Hospital, institution, or street address where death occurred.....<u>Bradley Street</u></p> <p>How long in hospital or institution?.....</p>		<p>2. USUAL RESIDENCE (HOME) OF DECEASED: <small>(For new born infants give residence of mother)</small></p> <p>State.....<u>Mad.</u> County.....<u>McComie</u></p> <p>City or town.....<u>Heron</u> <small>If outside city or town limits, write RURAL and give nearest town)</small></p> <p>Street No.....<u>Bradley Street</u> <small>(If rural, give LOCATION)</small></p> <p>2.(a) If veteran, name war.....</p>	
<p>3. (a) FULL NAME</p> <p><u>Arthur Linwood Moore</u></p>		<p>3. (b) Social Security Number</p> <p>.....</p>	

<p>4. Sex</p> <p><u>Male</u></p>	<p>5. Color or race</p> <p><u>White</u></p>	<p>6. (a) Single, married, widowed, or divorced</p> <p><u>Divorced</u></p>									
<p>6. (b) Name of husband or wife</p> <p><u>Carrie Mitchell</u></p>											
<p>7. Birth date of deceased (mo., day, yr.)</p> <p><u>Aug. 22-1903</u></p>											
<p>8. AGE:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: center;">Years</th> <th style="text-align: center;">Months</th> <th style="text-align: center;">Days</th> <th style="text-align: center;">If less than one day</th> </tr> <tr> <td style="text-align: center;"><u>42</u></td> <td style="text-align: center;"><u>11</u></td> <td style="text-align: center;"><u>2</u></td> <td style="text-align: center;">.....hrs.min.</td> </tr> </table>				Years	Months	Days	If less than one day	<u>42</u>	<u>11</u>	<u>2</u>hrs.min.
Years	Months	Days	If less than one day								
<u>42</u>	<u>11</u>	<u>2</u>hrs.min.								
<p>9. Birthplace</p> <p><u>Mandela Maryland</u> <small>Town, county, and state</small></p>											
<p>10. Usual occupation</p> <p><u>Laborer at</u></p>											
<p>11. Industry or business</p> <p><u>B. B. Bruns & Co. Lumber Co.</u></p>											
MOTHER FATHER	<p>12. Name</p> <p><u>Nicholas Moore</u></p>										
	<p>13. Birthplace</p> <p><u>Birah Maryland</u></p>										
	<p>14. Maiden name</p> <p><u>Jennie Reddish</u></p>										
	<p>15. Birthplace</p> <p><u>P.O. Salisbury Maryland</u></p>										
	<p>16. Informant</p> <p><u>Mr. Rodney Moore</u></p>										
<p>Address</p> <p><u>Heron Maryland</u></p>											
<p>17. Burial</p> <p><small>(Burial, cremation, or removal. Which?)</small></p> <p>Date thereof <u>July 26-46</u> <small>(month) (day) (year)</small></p>											
<p>Cemetery or crematory <u>Heron Heron</u></p>											
<p>Location <u>Heron Maryland</u></p>											
<p>18. Funeral director</p> <p><u>Holloway & Co. Walter K. Holloway</u></p>											
<p>Address</p> <p><u>Salisbury Maryland</u></p>											
<p>19. July 26 1946</p> <p><small>(Date rec'd by registrar)</small></p> <p style="text-align: right;">Registrar <u>Wm. Wallace</u></p>											

MEDICAL CERTIFICATION	
<p>20. DATE OF DEATH</p> <p><u>July 24th 1946</u> at <u>1230</u></p>	
<p>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</p> <p><u>July 15 1946</u> to <u>July 24 1946</u></p> <p>and that I last saw him/her alive on <u>July 24 1946</u></p>	
<p>Immediate cause of death</p> <p><u>Ulceration Clots</u></p>	<p>DURATION</p> <p><u>hours</u></p>
<p>Due to</p> <p>.....</p>	
<p>Due to</p> <p>.....</p>	
<p>Other conditions</p> <p>.....</p>	
<p><small>(Include pregnancy within 3 months of death)</small></p>	
<p>Major findings of operations</p> <p>..... Date of op.</p>	
<p>Autopsy results</p> <p>.....</p>	
<p>PHYSICIAN: Please underline the cause to which death should be charged statistically.</p> <p>.....</p>	
<p>22. VIOLENCE: If death was due to external causes, fill in the following;</p> <p>Accident, suicide, or homicide..... Date of</p> <p>Where did injury occur? <small>(City or town) (County) (State)</small></p> <p>Injured at home, farm, industry, public place (where?)</p> <p>Means of injury Injured at work?</p>	
<p>23. SIGNATURE</p> <p><u>[Signature]</u> M. D. or other</p> <p>Address..... Date signed <u>7/26/46</u></p>	

RECEIVED
AUG 5 1946
BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 933

1. PLACE OF DEATH:

County Wilcomica
 City or town Salisbury md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 100 years
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Wilcomica
 City or town Salisbury md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 104 Gordon St
 (If rural, give LOCATION)
 2. (a) If veteran, name war no

3. (a) FULL NAME

Maria Peters

3. (b) Social Security Number

no4. Sex Female 5. Color or race col 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife William H. Peters7. Birth date of deceased (mo., day, yr.) about 1876 8. (c) If alive, give age Don't know years8. AGE: Years about 75 Months 0 Days 0 If less than one day 0 hrs. 0 min.9. Birthplace Snow Hill md
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Same as above12. Name James P. Harris13. Birthplace Snow Hill md14. Maiden name Harriett Cornell15. Birthplace Snow Hill md16. Informant Edna W. Harris Helen ComphorAddress Salisbury md17. Burial Date thereof July 22, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory DauntlessLocation Salisbury md18. Funeral director James StewartAddress Salisbury md19. T. B. G. 19. 46 Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19. 46 at 10 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 19. 46 to July 18 19. 46and that I last saw him July 17 19. 46 alive onImmediate cause of death ConvulsionsChronic NephritisOther conditions Hypertension

(Include preposures within 8 months of death)

Major findings of operations no Date of op. noAutopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of noWhere did injury occur? no (City or town) (County) (State)Injured at home, farm, industry, public place (where?) noMeans of injury no Injured at work? no23. SIGNATURE G. Herke & Lemly MDAddress 502 E. Church St Date signed 7/20/46Salisbury md

RECEIVED
AUG 6 1940
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(21)

CERTIFICATE OF DEATH

Reg. Dist. No. 329

1. PLACE OF DEATH

County... Accomac

City or town... Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Worcester

City or town... Eden
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D. #1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Walter James Pusey

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

B. (c) If alive, give age... years
7. Birth date of deceased (mo., day, yr.) July 14 - 1932

8. AGE:

Years 13 Months 11 Days 21 hrs. min.

9. Birthplace P.B. Hoyt. Salisbury Md.
(Town, county, and state)

10. Usual occupation School Boy

11. Industry or business

12. Name Randie Pusey

13. Birthplace R.D. #1. Eden Md.

14. Maiden name Mae Smullen

15. Birthplace Accomac Co. Va.

16. Informant Mr. Randie Pusey

Address R.D. #1. Eden Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8 - 46
(month) (day) (year)

Cemetery or crematorium location

Worcester Co. Md.

18. Funeral director Hollingsworth & Miller R. Hollingsworth

Address Salisbury Md.

19. 7/8/46 (Date rec'd by registrar)

Registrar

Address

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5th 1946 at 6:33 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7.4.46 to 7.5.46

and that I last saw him alive on 7.5.46

Immediate cause of death Rupture of Stomach

DURATION

Due to Acute Gastric Dilatation

Due to Acute Appendicitis (day)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Acute Appendicitis

Date of op. 7.9.46

Autopsy results Acute dilatation imp. ftn

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lu L. Lacey MD

M. D. or other

Address Fruitland Date signed 7.8.

RECEIVED

JUL 12 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 197

CERTIFICATE OF DEATH

07422

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 15 hours & 9 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline
City or town Federalsburg - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Dutton Road
(If rural, give LOCATION)
2. (a) If veteran, name war ☒

3. (a) FULL NAME

Baby Boy Rosser

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife -
7. Birth date of deceased (mo., day, yr.) July 17, 1946
8. AGE: Years - Months - Days - If less than one day 15 hrs. 9 min.
6. (c) If alive, give age - years

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1946 at 10:51 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17, 1946 to July 17, 1946 and that I last saw him alive on July 17, 1946
Immediate cause of death decreased debility
DURATION 1/17/46
Due to Prematurity 7 mos. gestation
Due to -
Other conditions -
(Include pregnancy within 3 months of death)

9. Birthplace Salisbury, Maryland
(Town, county, and state)
10. Usual occupation Infant
11. Industry or business -
12. Name Everett Rosser
13. Birthplace Caroline County, Maryland
14. Maiden name Virginia Wright
15. Birthplace Caroline County, Maryland
16. Informant Everett Rosser
Address Federalsburg, Maryland
17. Burial Date thereof July 18, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Hill Crest Cemetery
Location Federalsburg, Maryland
18. Funeral director J. F. Frampton & Son
Address Federalsburg, Maryland
19. 7/18/46 Registrar Barrie L. Johnson
(Date rec'd by registrar)

Major findings of operations - Date of op. -
Autopsy results -
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide - Date of -
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -
Means of injury G. Metzler, M.D. Injured at work? -
23. SIGNATURE G. Metzler, M.D. M. D. or other -
Address Federalsburg, Md. Date signed 7/18/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 26 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

07423

Reg. Dist. No. 339

1. PLACE OF DEATH:

County Winnebago
 City or town Salisbury md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? About 4 years
 Hospital, institution, or street address where death occurred: na
 How long in hospital or institution? na

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County winnebago
 City or town Salisbury md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 25-Hawthorn St
 (If rural, give LOCATION)
 2.(a) If veteran, name war Don't know

3. (a) FULL NAME

Richard J. Sharf
 4. Sex male 5. Color or race a.a. 6. (a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Bessie H. Sharf
 yes yes 6.(c) If alive, give age Don't know years
 7. Birth date of deceased (mo., day, yr.) about 1877

8. AGE: 59 Years Months Days If less than one day
 hrs. min.

9. Birthplace na
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Same as above

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Daniel Bonaway

Address Salisbury md

17. Burial Date thereof July 30-1946
 (Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Hawthorn

Location Salisbury md

18. Funeral director Jamies Stewart

Address Salisbury md

19. 7/30 19 46 Bessie H. Sharf
 (Date registered by registrar) Registrar

3. (b) Social Security Number

178-07-5656

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27 19 46 at 9 P-M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical to death 19 46
 and that I last saw him alive on examined 19 46

Immediate cause of death

Chronic myocarditis

DURATION

6 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

J. Rademaker
Physician
Salisbury md
 Address Date signed 7/29/46

RECEIVED

AUG 6 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(159)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 hrs. 25 mins.
 Hospital, institution, or street address where death occurred:
Penninsula General Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Wicomico
 City or town Mardela
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Sharpe, Lawrence Cecil

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Infant

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 23-1946

8. AGE:

Years

Months

Days

If less than one day

23 hrs. 35 min.

9. Birthplace

P.B. Hopt. Salisbury Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

17. Burial

18. Cemetery or crematory

19. Location

20. Address

21. Date of op.

22. Autopsy results

23. PHYSICIAN: Please underline the cause to which death should be charged statistically.

24. VIOLENCE: If death was due to external causes, fill in the following:

25. Accident, suicide, or homicide

26. Where did injury occur?

27. Injured at home, farm, industry, public place (where?)

28. Means of injury

29. Injured at work?

30. Signature

31. M. D. or other

32. Address

33. Date signed

34. Date rec'd by registrar

35. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 19 46, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death.....

PrematurityDURATION 14 hrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

30. Signature Robert J. Gore M.D. or otherAddress WicomicoDate signed 7-24-46

RECEIVED

AUG 6 1946

BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

CERTIFICATE OF DEATH

07425

Reg. Dist. No. 335

1. PLACE OF DEATH:

County Wicomico
 City or town Parsonsburg md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Wicomico
 City or town Parsonsburg md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. na
 (If rural, give LOCATION) no
 2.(a) If veteran, name war no

3. (a) FULL NAME

Samuel Smith

3. (b) Social Security Number

4. Sex male 5. Color or race a. a. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Dolly Smith
 yes yes 6. (c) If alive, give age Don't know years

7. Birth date of deceased (mo., day, yr.) about 1875

8. AGE: Years about 28 Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Parsonsburg md
 (Town, county and state)

10. Usual occupation Farmer

11. Industry or business same as above

12. Name Daniel Smith

13. Birthplace Parsonsburg md

14. Maiden name Whaley

15. Birthplace Whaleyville md

16. Informant Mrs Dolly Smith

Address Parsonsburg md

17. Burial Burial Date thereof July 30, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Glasgow Hill

Location Parsonsburg md

18. Funeral director James P. Stewart

Address Salisbury md

19. 7/30 19 46 Leah L. Johnson
 (Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1946 at 3:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27, 1946 to July 27, 1946

and that I last saw him alive on July 20, 1946

Immediate cause of death Electric Shock DURATION July 26

Lightning July 26

Due to Myocarditis 6 mos.

Other conditions Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations no

Date of op. no

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of no

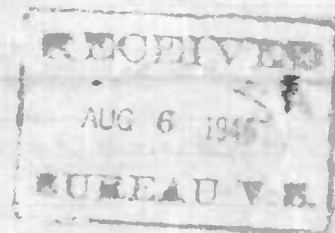
Where did injury occur? no (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) no

Means of injury no Injured at work? no

23. SIGNATURE G. P. Sembley MD M. D. or other

Address Salisbury md Date signed 7/29



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 888

1. PLACE OF DEATH:

County.....Wicomico
 City or town.....Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....60 Years
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution?.....3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md County.....Wicomico
 City or town.....237 Camden Ave
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....Salisbury
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mary Tilghman Strudwick

3. (b) Social Security Number

4. Sex.....female 5. Color or race.....white 6. (a) Single, married, widowed, or divorced.....widowed
 8. (b) Name of husband or wife.....Fred Nash Strudwick
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....June 18, 1896
 8. AGE: Years.....60 Months.....1 Days.....3 If less than one day..... hrs. min.

9. Birthplace.....Salisbury, Md
(If any county, and state)10. Usual occupation.....At home

11. Industry or business.....

12. Name.....Williams B. Tilghman13. Birthplace.....Salisbury, Md14. Maiden name.....Annie E. Bell15. Birthplace.....Potomac, Miss.16. Informant.....Mrs. E. Wilson BoothAddress.....Salisbury, Md17. (Burial, cremation, or removal. Which?).....Burial Date thereof.....7/22/46
(month) (day) (year)Cemetery or crematory.....Parsons CemeteryLocation.....Salisbury, Md18. Funeral director.....The Hill & Johnson Co.Address.....Salisbury, Md19. 7/29 4/6 Harriet E. Johnson
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....July 21, 1946 1230A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug 19, 45 to July 21, 46
 and that I last saw her alive on 7-20 1946

Immediate cause of death.....

Carcinoma of
abdomen.
Papillary cystadenoma
 Due to.....
 Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....Metastatic Carcinoma
of abdomen Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work.....

23. SIGNATURE.....Harriet E. Johnson M. D. or otherAddress.....Salisbury, Md Date signed.....7-22-46

RECEIVED

AUG 1 1945

BUREAU V K

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH



Reg. Dist. No. 333

07427

1. PLACE OF DEATH:

County Worcester
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 weeks
 Hospital, institution, or street address where death occurred:
Pen. General Hospital
 How long in hospital or institution? 8 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Worcester
 City or town Ocean City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Pennino, Charles Henry

3. (b) Social Security Number

4. Sex <u>male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>married</u>
6. (b) Name of husband or wife <u>May Pennino</u>		
7. Birth date of deceased (mo., day, yr.) <u>May 24, 1880</u>		
8. AGE: Years <u>66</u> Months <u>1</u> Days <u>12</u> If less than one day _____ hrs. _____ min.		
9. Birthplace <u>Berlin W. Va. md R.D.</u> (Town, county, and state)		
10. Usual occupation <u>Hotel Owner</u>		
11. Industry or business		
12. Name <u>Samuel H. Pennino</u>		
13. Birthplace <u>Maryland</u>		
14. Maiden name <u>Hester Smith</u>		
15. Birthplace <u>Delaware</u>		
16. Informant <u>Mrs. Charles H. Pennino</u> Address <u>Ocean City md.</u>		
17. <u>Burial</u> Date thereof <u>7/8/46</u> (Burial, cremation, or removal. Which?) (month) (day) (year)		
Cemetery or crematory <u>Evergreen</u>		
Location <u>Berlin md.</u>		
18. Funeral director <u>Anna R. Burbo</u> Address <u>Berlin md.</u>		
19. <u>7/8</u> 19 <u>46</u> <u>Charles H. Pennino</u> (Date rec'd by registrar) Registrar		

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 19 46 at 2:17 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 19 46 to June 6 19 46 and that I last saw him alive on July 6 19 46

Immediate cause of death Pulmonary embolism DURATION 10 days

Due to acute appendicitis
Pericystic abscess

Due to _____

Other conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations acute gang. appendicitis
Pericystic abscess Date of op. May 29, 1946

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE L. A. Rademacher M. D. or other _____
 Address Salisbury md Date signed 7/6/46

RECEIVED

JUL 12 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

Reg. Dist. No. 07428 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Peninsula GeneralHow long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Townsend Mrs. Mary H.

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white married6. (b) Name of husband or wife George H. Townsend6. (c) If alive, give age 82 years7. Birth date of deceased (mo., day, yr.) January 13 - 18638. AGE: Years 83 Months 6 Days 0 If less than one day _____ hrs. _____ min.9. Birthplace Berlin, Maryland, MD
(Town, county, and state)10. Usual occupation Homemaker11. Industry or business None12. Name Jessie Turner13. Birthplace Delaware14. Maiden name Charlotte Griffith15. Birthplace Delaware16. Informant Mrs. John HunterAddress Salisbury, MD17. Burial, cremation, or removal. Which? Buried Date thereof July 18, 46
(month) (day) (year)Cemetery or crematory Pinet, ChurchyardLocation Salisbury18. Funeral director Harmon & SonAddress Snow Hill, MD19. (Date received by Registrar) 7/15/4620. Signature Barrett E. Johnson RegistrarAddress Salisbury, MD Date signed 7/13/46

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 19 46, at 12:45 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 19 46, to July 13 19 46, and that I last saw him/her alive on July 13 19 46Immediate cause of death Several peritonitis DURATION 4 daysDue to acute gang. & perf. appendicitis 1 week

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Gen Peritonitis - Perf. gang. appendix Date of op. 7/12/46Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Barrett E. Johnson M. D. or other _____Address Salisbury, MD Date signed 7/13/46

RECEIVED

JUL 22 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WorcesterCity or town Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 31 days

3. (a) FULL NAME

Virginia May Townsend

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

John Townsend6. (c) If alive, give age 58 years

7. Birth date of

deceased (mo., day, yr.)

Sept 11, 1894

8. AGE:

Years

Months

Days

If less than one day

511011

hrs.

min.

9. Birthplace

Berlin Wm. Co. Md R.F.D.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Parker Payne

13. Birthplace

Berlin Md R.F.D.

14. Maiden name

Martha Hadden

15. Birthplace

Berlin Md R.F.D.

16. Informant

Mr John Townsend

Address

Berlin Md R.F.D.

17.

(Burial, cremation, or removal. Which?)

Buried

Date thereof

7/24/46

Cemetery or crematory

Riverside

Location

Berlin Md R.F.D.

18. Funeral director

Amos R. Burbage

Address

Berlin Md

19.

(Date registered by registrar)

7/24/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md County Worcester

City or town

Berlin R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (c) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 22 1946 at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 18 1946 to July 22 1946and that I last saw H.R. alive on July 21 1946

Immediate cause of death

cachexia, inanition

DURATION

Due to

Cervical uterine grade IV6 mo.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

uterine fibroids in situadvanced carcinoma Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William B. Long M.D. M.D. or otherAddress 504 N. Division St.Date signed July 23/46

RECEIVED
AUG 6 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 870

CERTIFICATE OF DEATH

07430

Reg. Dist. No. 337

1. PLACE OF DEATH:

County Wicomico
 City or town Tyaskin
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Wicomico
 City or town Tyaskin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex M 5. Color or race Col 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Jedie Wainwright

7. Birth date of deceased (mo., day, yr.) April 10, 1883 6. (c) If alive, give age _____ years

8. AGE: Years 63 Months 3 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Tyaskin, Wicomico, Md
(Town, county, and state)10. Usual occupation Home work11. Industry or business own home12. Name Robert Wainwright13. Birthplace Clara, Md14. Maiden name Elizabeth Conway15. Birthplace Clara, Md16. Informant Mary E. HesticksAddress Tyaskin, Md.17. Burial Date thereof July 24, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetary or crematory private CemeteryLocation Mar Messick's place18. Funeral director L. J. MessickAddress Baltimore, Md.19. July 23 19 46 Registrar R. W. Wolf
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 46 at 4:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 12 19 46 to July 21 19 46and that I last saw him alive on July 21 19 46

Immediate cause of death

Cerebral hemorrhage DURATION 9 daysDue to arterio-sclerosis 2Due to Hypertension 2

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert J. Sore M. D. or otherAddress Wante Cove Date signed 7-23-46

RECEIVED
AUG 6 1946
BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07431 333

1. PLACE OF DEATH:

County ShiromioCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

John B. Pavers HomeHow long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County ShiromioCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. John B. Pavers Home
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

Melissa Staud

3. (b) Social Security Number

✓4. Sex Female5. Color or race White6.(a) Single, married, widowed, or divorced Single6.(b) Name of husband or wife ✓6.(c) If alive, give age ✓ years7. Birth date of deceased (mo., day, yr.) October 29, 18758. AGE: Years 75 Months 9 Days 1
If less than one day hrs. min.9. Birthplace Salisbury
(Town, county, and state) (None)10. Usual occupation None11. Industry or business NoneFATHER
MOTHER12. Name Louis Staud13. Birthplace Perryopolis14. Maiden name Rosanna Staud15. Birthplace New York State16. Informant Sup. John B. Pavers HomeAddress Salisbury, Md.17. Burial Date thereof 8/1/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. MaryLocation Carroll Co. Md. Inter18. Funeral director St. Hill & Son, W. O.Address Salisbury, Md.19. 8/1/46 19 46 Carrie L. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 19 46 at 11 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24th 19 46 to July 29th 19 46and that I last saw him alive on July 29th 19 46Immediate cause of death EmbolismDURATION 5Due to Clot in HypocordDue to myocardial infarctionOther conditions after two hours

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of NoneWhere did injury occur? None (City or town) (County) (State)Injured at home, farm, industry, public place (where?) NoneMeans of injury None Injured at work? None23. SIGNATURE Carrie L. Johnson M. D. or otherAddress Salisbury, Md. Date signed Aug 1, 1946

RECEIVED
AUG 6 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07432

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 hrs - 50 min

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 8 hrs - 50 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County City or town Philadelphia
(If outside city or town limits, write RURAL and give nearest town)Street No. 226 E. Sheldon St.
(If rural, give LOCATION)2.(a) If veteran, name war

3. (a) FULL NAME

West Wayne4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single6.(b) Name of husband or wife 7. Birth date of deceased (mo., day, yr.) Oct. 20 1930 6.(c) If alive, give age years8. AGE: Years 15 Months Days If less than one day hrs. min.9. Birthplace Phila. Pa.
(Town, county, and state)10. Usual occupation 11. Industry or business FATHER 12. Name Arley Joseph West13. Birthplace Delaware, SussexMOTHER 14. Maiden name Dorothy Button15. Birthplace Phila. Pa.16. Informant Arley Joseph WestAddress 226 East Sheldon St.17. Burial Date thereof Aug 5 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington MemorialLocation Phila. Pa.18. Funeral director H. B. HickmanAddress Millsboro, Del19. 7/30/46 19 46 Harriet E. Johnson Registrar
(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 19 46, at 2:35 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical 19 and that I last saw him alive on 3 years ago 19 Immediate cause of death lacerated BrainDURATION 7 dayDue to Due to Other conditions

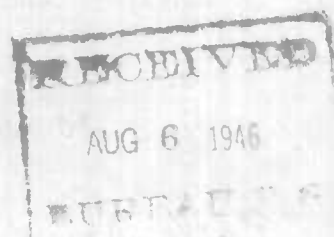
(Include pregnancy within 3 months of death)

Major findings of operations noneDate of op. Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7/29/46Where did injury occur? Millsboro Sussex (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury Truck struck Injured at work? noculvert23. SIGNATURE Harriet E. Johnson M. D. or otherAddress Salisbury, Md Date signed 7/30/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14

CERTIFICATE OF DEATH

Reg. Dist. No. 07433 32

1. PLACE OF DEATH:

County Salisbury
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Salisbury
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. RD #2 Pittsville Md.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Elsie Mae Wilkins

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

May 26th 1932

8. AGE:

Years

Months

Days

If less than one day

1416

hrs.

min.

9. Birthplace

Seabrook Md.
(Town, county, and state)

10. Usual occupation

School girl

11. Industry or business

MOTHER FATHER

12. Name

Frederick S. Wilkins

13. Birthplace

RD. Pomellville Md.

14. Maiden name

Stella Mae Adkins

15. Birthplace

RD. Snow Hill Md.

16. Informant

Mr. Frederick S. Wilkins

Address

RD. #2 Pittsville Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 8th 1946
(month) (day) (year)

Cemetery or crematory

Wilkins

Location

Near Pomellville Md.

18. Funeral director

Holloway + G. Walter R. Holloway

Address

Salisbury Md.

19.

(Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH July 2nd 1946 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1st 1946 to July 2nd 1946
and that I last saw him alive on July 2nd 1946

Immediate cause of death

T.B. Meningitis?Due to Tuberculous meningitis, suppurativeThe final report reads: Tubercle bacilli isolated by cultural.Due to lated by cultural.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Nature of injury Injured at work?

23. SIGNATURE

J. H. Hall
Address Salisbury Date signed 7/5/46

RECEIVED

JUL 12 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Giamme

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-0

CERTIFICATE OF DEATH

07474

Reg. Dist. No. 333

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

46

1. Barrett

Registrar

Address

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 6th

19

at

46

10

29

A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-9-46

to

7-9-46

19

and that I last saw h.

im.

alive on

7-9-46

19

Immediate cause of death

Carcinoma of

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED
JUL 12 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Penninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. P.O. # 4
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Wimberon Mrs. Sarah Collins

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(c) Single, married, widowed, or divorced Widow6.(b) Name of husband or wife Sampson Ayer Wimberon

7. Birth date of

deceased (mo., day, yr.)

Nov. 18-1862

8. AGE:

Years

Months

Days

If less than one day

83729

hrs.

min

9. Birthplace

nearBerlin Md.

(Town, county, and state)

10. Usual occupation

Home work

11. Industry or business

at Home

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Date thereof

(Burial, cremation, or removal. Which)

(month) (day) (year)

Cemetery or crematory

Location

18. Registrar

19. Date rec'd by registrar

19. 46

20. Date of death

21. Cause of death

22. Signature

23. Address

24. Date signed

25. Address

26. Date signed

27. Address

28. Date signed

29. Address

30. Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 17th 1946 at 8:25 A.M.

21. I certify that death occurred on the date above stated: that I attended deceased from

Medical Examination Reportand that I last saw him alive on 19

Immediate cause of death

Fracture of right legDue to Fall at home

Due to

Other conditions Arthritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of July 8th 1946Where did injury occur? Salisbury Wicomico Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) HomeMeans of injury FallInjured at work? No23. SIGNATURE Class T. FrisnerAddress SalisburyDate signed 7/17/46

